TRICARE
Latin America & Canada

Fax Coversheet

TO

To:	**TRICARE Region 15 Lead Agent**	Attn:	**Claims Processing**
Fax:	706.787.3024 or DSN: 773.3024	Phone:	706-787-2424 or DSN: 773-2424
Date:		Pages:	, including coversheet
Re:	TLAC Active Duty Service Member Claims		

FROM

From:			
Fax:		Phone:	
Country:		Unit:	

CLAIMS CHECKLIST

For Active Duty Service Member Claims for TRICARE Latin America and Canada Enrollees.

- ☐ I was/am enrolled into TRICARE Latin America and Canada, Region 15, at the date(s) of service of this claim.
- ☐ I used the TRICARE Latin America & Canada Medical Claim/Reimbursement Request (For All TLAC Active Duty Service Members).
- ☐ All blocks of the claim form, 1-5, are filled out completely.
- ☐ I have attached the itemized bill(s) for the care received.
- ☐ I have attached the receipt(s) for the care received.
- ☐ I have attached a referral from the Embassy Health Unit (if applicable)
- ☐ I have filled out the Electronic Funds Transfer Form (if this is the first claim filed)
- ☐ I have attached a copy of a voided check (if this is the first claim filed)

PLEASE REMEMBER: Any missing/incomplete information will halt the claims process. If there is missing/incomplete information faxed to us, you will be contacted via fax/e-mail and notified of what information needs to be submitted. If within **10 days** the requested information is not received in our office, we will discontinue the pursuit of reimbursing this claim. Thank you for your help and do not hesitate to call our office with any questions.

Additional Comments: